DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Chronic Health Homes Workgroup

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Today's Agenda

- Review of 5/17 Meeting
  - Financing Models: New York and Missouri
  - Target Population
- Discussion of Behavioral Health Integration Principles with regard to:
  - Target Population
  - Services
- Questions/Discussion

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Missouri Health Home

- CMHC HH team is physician-led with PCP Consultant, a Nurse Care Manager(s),and a HH admin support staff
  - Optional: treating psychiatrist, MH case manager, pharmacy, peer specialists, housing representatives, employment or educational specialists, etc.
- Single EHR portal from MO HealthNet for all Medicaid Providers

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Financing Model

- Primary Care Physician Consultant: 1 hr p/ enrollee p/year @ $105
- Health Home Director: 1 FTE/500 enrollees @ $115,000 p/year
- Nurse Care Manager: 1 FTE/250 enrollees @ $105,000 p/year
  - caseloads may vary based on the number of consumers they serve who do not have a community support specialist
- Administrative Support Staff: 1 FTE/500 enrollees

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Financing Model

PMPM is $78.74 to provide ALL coordinatio

services in the individual's person-centered plan.

- $35.00 for a nurse care manager who coordinates care via 12 tasks <250 enrollees; and
- $12.50 for a PCP consultant who devotes one hour p/enrollee p/year to provide four services; and
- $19.17 for a Health Home director who oversees care for 500 enrollees through five activities; and
- $12.07 for one admin support staff person who handles seven administration tasks related to 500 enrollees.

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Financing Model: Missouri

Performance Measures

- MO will propose that practice sites could be paid up to 50% of the value of the reduction in total health care PMPM costs for the practice site's attributed FFS consumers, relative to prior year experience.
- Savings will be distributed on a sliding scale relative to a set of site-specific preventive and chronic care measures generated and reported by the practice and subject to audit.
- Dual eligible MA/MC to be included if CMS agrees to share MC savings for dual eligibles with state

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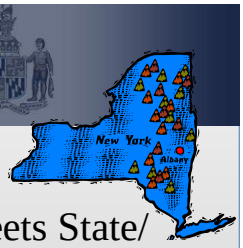

New York Health Home

- HH providers can be any entity that meets State/ Federal requirements.
- Teams of medical, MH, SA providers, LCSWs, RNs, etc. led by a dedicated care manager
  - Optional: nutritionists/dieticians, pharmacy, peer specialists, housing representatives, entitlement and employment specialists, etc.
- Single electronic care record for care manager, team

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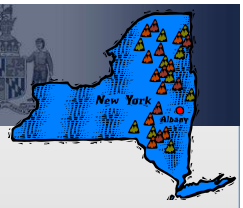

Financing Model:

- The PMPM is based on severity of illness, calculated using the 3M Clinical Risk Grouping Tool. The clinical risk groups are low, mid, and high.
- The care manager caseload can vary from 12:1 to 140:1.
- The rates are differentiated by region (upstate vs. downstate).

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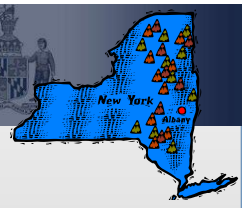

Financing Model

Basic Health Status	Dx Description	Severity of Illness	Acuity Score	Downstate Payment	Upstate Payment
Pairs Chronic	Schizophrenia & Other	Mid	7.1434	$166	$134
Pairs Chronic	Diabetes & Hypertension	Low	1.6947	$39	$32
Single SMI/SED	Schizophrenia	High	16.6197	$387	$311
Single SMI/SED	Conduct, Impulse Control	Low	6.3574	$148	$119

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Basic Health Status	Severity of Illness	Avg Care Mgmr Ratio	Eligible Recipients (Down/Up State)	Avg Acuity Score	Avg PMPM (Down/Up State)
Single SMI/SED	Low Mid High	79:1 61:1 12:1	50k/25k 19k/10k 260/60	6.3 8.0 16.5/16.7	$148/119 $189/150 $385/312
Pairs Chronic	Low Mid High	116:1 76:1 37:1	277k/89 104k/37k 18k/6k	3.1/4 6.4/7 10.9/11.4	$73/75 $151/132 $255/214
Triples Chronic	Low Mid High	89:1 62:1 34:1	16k/5k 22k/8k 8k/3k	5.4/5.7 7.9/8.3 11.3/11.9	$127/108 $185/155 $266-223

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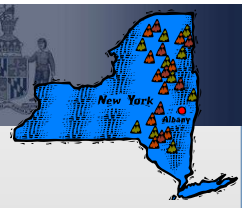

Financing Model

- Performance: 10% withhold based on performance measures to start, based on CMS approval.
- No volume adjustment, but may be revisited if there are very small, rural health homes.
- PMPM paid at 80% for outreach and engagement for 3 months. Once the person is assigned a care manager and has consented to enrollment, the full PMPM can be billed

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Integration Principles

The criteria will be used to evaluate our three financing options.

1. Best ensures delivery of the right service, in the right place, at the right time, by the right practitioner
2. Best ensures positive health outcomes in behavioral health and somatic care using measures that are timely and transparent
3. Best ensures preventive care, including early identification and intervention
4. Best ensures care across an individual's lifespan
5. Best ensures positive consumer engagement

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Integration Principles

6. Best aligns with treatment for chronic conditions
7. Best ensures the delivery of culturally and linguistically appropriate (CLAS) and competent services that are evidence-based and informed by practice-based evidence
8. Best ensures that the system is adaptable over time, as other payment and delivery system reforms occur, without loss in value or outcomes
9. Best ensures program integrity and cost-effectiveness
10. Best ensures administrative efficiencies at state, local, plan, provider, and consumer/family levels
11. Best ensures seamless transitions as service needs change, and as program eligibility changes

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Reminder: Eligibility Basics

Medicaid beneficiaries with:

- Two+ chronic conditions (mental health, substance abuse, asthma, diabetes, heart disease, overweight, or others as approved by CMS);
- One chronic condition and at risk for a second; or
- Serious and persistent mental health condition.

√ **CAN** target by condition or geography

X Cannot exclude dual eligibles

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MD Draft Population Criteria

The consumer has: (1) a serious and persistent mental illness, (2) an opioid substance use disorder or (3) other significant, diagnosed drug use disorder. That results in at least two of….

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Draft Target Population Criteria

- An inability to establish or maintain a personal social support system; and/or
- Frequent disruption of role performance as evidenced by an inability to obtain or maintain employment and/or conduct daily living chores such as care of living environment without ongoing treatment, therapeutic and/or rehabilitative services; and/or
- Frequent or consistent interference with daily life due to impaired thinking; and/or
- Disruption in the ability to provide for his/her own needs such as food, clothing, shelter, and transportation. Unable to maintain hygiene, diet, clothing, and prepare food without ongoing treatment, therapeutic and/or rehabilitative services.

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Draft Target Population Criteria

OR The Consumer:

- had 2+ episodes of: (1) inpatient care for a mental illness or (2) medically managed detoxification treatment for a substance use disorder within the preceding 24 months; or
- has been treated by a crisis team 2+ times within the preceding 24 months; or
- the adult has, in the last 24 months, been committed by a court, or the adult's commitment has been stayed or continued; or
- exhibits inability to maintain conduct within the limits prescribed by law as evidenced by repeated involvement with law enforcement.

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Translating Mandates Into Services

- **Comprehensive care management**
  - Intake and assignment of team roles
  - Assessment of preliminary needs with comprehensive health assessment
  - Development of culturally/linguistically competent person-centered, trauma-informed plan of care
- **Care coordination and health promotion**
  - Facilitate consumer's health education/literacy
  - Referral and linkage to tobacco cessation, nutritional counseling, and physical activities
  - Link consumer to services needed to support person-center, trauma-informed plan of care; follow-up on referrals

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Translating Mandates Into Services

- **Comprehensive transitional care, including appropriate follow-up from inpatient to other settings**
  - Streamline plans of care
  - Interrupt/prevent unnecessary inpatient/ED usage
  - Shift focus from reactive or crisis care to preventive care
- **Patient and Family Support**
  - Facilitate participation in the ongoing revision of person-center plan of care
  - Focus on programs to build ability to self-manage condition, medications, etc.

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Translating Mandates Into Services

- **Referral to community and social services, if relevant**
  - Obtain and maintain eligibility for public assistance benefits, housing, legal services, etc.
  - Referral and follow-up to peer support, social skills building groups and activities to prevent isolation
- **Use of HIT to link services, as feasible and appropriate**
  - Structured information systems, policies, procedures & practices to create, document, execute, and update a plan of care for every consumer
  - EHR accessible to the interdisciplinary team of providers
  - Ability to share information with somatic, psychiatric, and rehabilitative service providers and State for QI

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Points to Consider

- Which **current** locus (or loci) of MH or SA services could become a health home?
  - OMHCs, TCMs, methadone programs, hospital-based SA programs?
- Start-Up/Training Costs
- Ongoing ability to deliver six mandated services with continuous improvement
- Sustainability/Economies of Scale

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Questions/Discussion

Next Meeting:

Thursday, July 12

10AM-noon

UMBC Tech Center

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